DEPARTMENT OF THE ARMY
HEADQUARTERS, PACIFIC REGIONAL MEDICAL COMMAND
1 JARRETT WHITE ROAD
TRIPLER AMC, HAWAII 96859-5000

REPLY TO
ATTENTION OF

MCHK-PST Date: _____
Tri-Service Addiction Recovery Facility (TRISARF)

SUBJECT: TRISARF INFORMED CONSENT & TREATMENT CONTRACT

I, _____, understand the following:

Please initial in the blank space next to each statement below to acknowledge your understanding.

ATTENDANCE

_____I will make my own transportation arrangements and will be on time for all scheduled treatment activities.
_____I will call TRISARF if I will be late. I will fill out, in advance, the Request To Be Excused From Treatment form and submit it to my counselor for approval only in the event I cannot reschedule a pre-existing appointment. I will be considered an unauthorized absence if I do not comply with the above and my Command will be notified of my absence immediately.

TREATMENT

_____ I will follow my treatment plan and maintain abstinence during treatment.
_____ I will **abstain from any alcohol, illegal drugs, prescription drugs** that have not been prescribed for my use in treatment and drugs discouraged by the military (spice, bath salts).
_____ I am subject to weekly and random **drug and alcohol screening** during treatment.
_____Tripler is a training hospital; therefore, interns, residents or other professionals-in-training may participate in my care.

AFTER-HOURS RECOVERY ACTIVITIES

_____I will complete daily journals and all homework assignments.
_____I will not go to activities or places that are dispensers of alcohol and illegal drugs (liquor stores, Raves, head shops, concerts).
_____I will **not be a designated driver** for others during the duration of treatment at TRISARF.
_____I will attend three12-Step meetings (AA, NA, ACOA, OA, SLAA, etc.) a week while I am in treatment. I understand my counselor will make changes based on my treatment needs. I will discuss additional alternative recovery activities with my counselor. I understand the Friday introductory AA meeting on TRISARF does <u>not count</u> toward the three meetings a week mandatory requirement. I will begin 12-Step meetings in Week One.
_____I will get signature verifications of all 12-Step meetings I attend while in treatment.
_____I understand that deviations from my treatment plan will be reviewed by my Treatment Team and can result in termination of treatment at TRISARF.

PATIENT'S SIGNATURE _____ DATE _____

COUNSELOR'S SIGNATURE _____ DATE _____

Last Name: _____ First Name: _____
Last 4 of SSN: _____ DOB: _____